PRINTED: 09/18/2009 FORM APPROVED OMB NO. 0938-0391

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | | IDENTIFICATION NUMBER: | | IULTIP LDING | PLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED | |
|---|---|--|-------------------|-----------------|--|-------------------------------|----------------------------|
| | | 297130 | B. WIN | IG | | 07/17/2009 | |
| | OVIDER OR SUPPLIER | SERVICES, INC | , | 3 | EET ADDRESS, CITY, STATE, ZIP CODE 14 NEBRASKA AVENUE IENDERSON, NV 89015 | | = |
| (X4) ID PREFIX TAG | (EACH DEFICIENC | ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION) | ID PREF TAC | | PROVIDER'S PLAN OF CORREC (EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPR DEFICIENCY) | JLD BE | (X5) COMPLETION DATE |
| G 000 | INITIAL COMMENTS | 3 | G | 000 | | | |
| | a result of the Medica under 42 CFR Part 4 | ficiencies was generated as are re-certification survey 84 - Home Health Services, ency from 7/14/09 through | | | | | |
| | was 15. Eight clinica | the first day of the survey I records were reviewed, record. Three home visits | | | | | |
| | by the Health Division prohibiting any criminactions or other claim | clusions of any investigation in shall not be construed as leal or civil investigations, as for relief that may be under applicable federal, | | | | | |
| | The following regulat identified: | ory deficiencies were | | | | | |
| G 102 | The HHA must provionotice of the patient's furnishing care to the | de the patient with a written | G | 102 | | | |
| | Based on interview a failed to ensure the N | not met as evidenced by: nd record review, the agency lotice of Rights was provided of care for 1 of 3 patients #2). | | | | | |
| | Findings include: | | | | | | |
| | Patient #2 | | | | | | |

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

TITLE

(X6) DATE

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION A. BUILDING | | | (X3) DATE SURVEY COMPLETED | | |
|--|--|---|---|------|--|----------------------------|----------------------------|--|
| | | 297130 | B. WIN | 1G _ | | 07/1 | 7/2009 | |
| | OVIDER OR SUPPLIER | SERVICES, INC | • | | REET ADDRESS, CITY, STATE, ZIP CODE 314 NEBRASKA AVENUE HENDERSON, NV 89015 | | | |
| (X4) ID PREFIX TAG | (EACH DEFICIENC | ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION) | ID PREF TAG | IX | PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPRO DEFICIENCY) | JLD BE | (X5) COMPLETION DATE | |
| G 102 | Continued From page | e 1 | G | 102 | 2 | | | |
| | including abnormality diabetes mellitus, ma hypertension. On 6/1/09, the patien | al end of the left humerus | | | | | | |
| G 116 | Patient #2 indicated t case did not mention patient's rights. The | n 7/15/09 in the afternoon, he nurse who opened the anything regarding the patient indicated no one had about patient's rights during | G | 116 | 6 | | | |
| | | ght to be advised of the free HHA hotline in the | | | | | | |
| | patient in writing of the home health hotline of hours of its operation hotline is to receive colocal HHAs. The patients | e HHA must advise the the telephone number of the the stablished by the State, the the, and that the purpose of the the omplaints or questions about tent also has the right to use the omplaints concerning the the advanced | | | | | | |
| | Based on interview, the toll free home hea | ailable to 3 of 3 patients | | | | | | |

| | | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) M A. BUI | | PLE CONSTRUCTION G | (X3) DATE SURVEY COMPLETED | | |
|--------------------------|--|--|-------------------|-----|--|-------------------------------|----------------------------|--|
| | | 297130 | B. WIN | IG | | 07/1 | 7/2009 | |
| | OVIDER OR SUPPLIER | SERVICES, INC | | 3 | REET ADDRESS, CITY, STATE, ZIP CODE B14 NEBRASKA AVENUE HENDERSON, NV 89015 | • | | |
| (X4) ID PREFIX TAG | (EACH DEFICIENC | ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION) | ID PREF TAG | IX | PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPRO DEFICIENCY) | LD BE | (X5) COMPLETION DATE | |
| G 116 | Continued From page | 2 | G | 116 | | | | |
| | Findings include: | | | | | | | |
| | Patient #2 | | | | | | | |
| | including abnormality | ted on 1/5/08 with diagnoses of gait, insulin dependent cular degeneration and | | | | | | |
| | On 6/1/09, the patien fracture to the proxim (top end of the upper | al end of the left humerus | | | | | | |
| | Patient #2 indicated r | interview in the afternoon, no one mentioned the toll ine telephone number. | | | | | | |
| | Patient #3 | | | | | | | |
| | Patient #3 was admit diagnoses including of pulmonary disease at | chronic obstructive | | | | | | |
| | Patient #3's home, th | AM during an interview in e patient indicated no one e home health hotline phone tial visit or during any | | | | | | |
| | | he agency folder containing work could not be located. | | | | | | |
| | Patient #4 | | | | | | | |
| | Patient #4 was admit diagnoses including of insulin dependent dia peripheral vascular d | ppen wound on back, non betes mellitus and | | | | | | |

| I ' ' | | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION A. BUILDING | | | (X3) DATE SURVEY COMPLETED | |
|--------------------------|--|--|---|---|---|-------------------------------|----------------------------|
| | | 297130 | B. WIN | IG_ | | 07/1 | 7/2009 |
| | OVIDER OR SUPPLIER | SERVICES, INC | | 3 | REET ADDRESS, CITY, STATE, ZIP CODE B14 NEBRASKA AVENUE HENDERSON, NV 89015 | | |
| (X4) ID PREFIX TAG | (EACH DEFICIENC | ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION) | 1 | ID PROVIDER'S PLAN OF CO PREFIX (EACH CORRECTIVE ACTION TAG CROSS-REFERENCED TO THE DEFICIENCY) | | _D BE | (X5) COMPLETION DATE |
| G 116 | Continued From page | e 3 | G | 116 | | | |
| | Patient #4 indicated r | nome visit around 11:00 AM, no one mentioned the se home health hotline | | | | | |
| | | she was unable to locate the he was given during the first | | | | | |
| G 121 | 484.12(c) COMPLIAN PROFESSIONAL ST | | G | 121 | | | |
| | professional standard | f must comply with accepted ds and principles that apply shing services in an HHA. | | | | | |
| | Based on observation ensure professional s | ontrol and bag technique for | | | | | |
| | Findings include: | | | | | | |
| | Patient #2 | | | | | | |
| | including abnormality diabetes mellitus, ma hypertension. On 6/1 | ted on 1/5/08 with diagnoses of gait, insulin dependent cular degeneration and 1/09, the patient fell and to the proximal end of the lof the upper arm). | | | | | |
| | the Certified Home H purse containing bloc | ernoon during a home visit, ealth Aide (CHHA) placed a od pressure monitoring Patient #2's kitchen table | | | | | |

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | A. BUILDING | | | (X3) DATE SURVEY COMPLETED | |
|--|--|--|-------------|--|---|-------------------------------|----------------------------|
| | | 297130 | B. WIN | IG_ | | 07/1 | 7/2009 |
| | ROVIDER OR SUPPLIER S CARE HOME HEALTH | SERVICES, INC | • | 3 | REET ADDRESS, CITY, STATE, ZIP CODE 814 NEBRASKA AVENUE HENDERSON, NV 89015 | | |
| (X4) ID PREFIX TAG | (-, -, -, -, -, -, -, -, -, -, -, -, -, - | | | ID PROVIDER'S PLAN OF COF PREFIX (EACH CORRECTIVE ACTION TAG CROSS-REFERENCED TO THE A DEFICIENCY) | | LD BE | (X5) COMPLETION DATE |
| G 121 | CHHA removed the brown and respirations. The equipment back into the items. After the vital signs with the CHHA assisted For Patient #3 Patient #3 Patient #3 was admit diagnoses including or pulmonary disease a con 7/14/09 in the mode without gloves on, the (LPN) touched and poshe assessed for any her hands, the LPN roto retrieve a stethoso condition of the equipment hand hygiene. Patient #4 Patient #4 Patient #4 Patient #4 Patient #4 Patient #4 On 7/15/09 around 1 The registered nurse barrier and prepared | erneath the purse. The blood pressure cuff from the atient's blood pressure, pulse e CHHA placed the the purse without cleaning were taken and documented, Patient #2 with a shower. Itted on 4/21/07 with chronic obstructive and osteoarthrosis. Inning during a home visit, the Licensed Practical Nurse alpated Patient #3's feet as a y swelling. Without washing eached into her nursing bag sope. It is vital signs, the LPN tent to the nursing bag without tent and before performing the an open wound on the upper pendent diabetes mellitus and disease. 1:00 AM during a home visit, (RN) placed her bag on a | G | 121 | | | |

| STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER: | | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION A. BUILDING | | | (X3) DATE SURVEY COMPLETED | |
|---|--|--|---|-----|--|-------------------------------|----------------------------|
| | | 297130 | B. WIN | IG | | 07/1 | 7/2009 |
| | OVIDER OR SUPPLIER | SERVICES, INC | • | 3 | REET ADDRESS, CITY, STATE, ZIP CODE 14 NEBRASKA AVENUE IENDERSON, NV 89015 | | |
| (X4) ID PREFIX TAG | (EACH DEFICIENC | ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION) | ID PREF TAG | IX | PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPRO DEFICIENCY) | LD BE | (X5) COMPLETION DATE |
| G 121 | blood pressure, doffer performed no hand he checked the patient's gloves; performed har patient's temperature a new pair of gloves a sanitizer wipe and put the nursing bag with the nursing from Patient same gloves on, the normal saline (NS) at RN doffed the gloves donned new gloves, covered with dry drest tape. The RN chang hand hygiene between the RN cleaned the sanitizer wipe and plabag (with gloves still of non-sterile cotton to outside pocket of a labagged old dressing trash (out in the hallw assisted living facility gloves, performed has the nursing bag. Without gloves on, the feet from the left side on and backed feet of the right foot and sanything like that?" The RN instructed the when sitting watching | des and took Patient #4's d (removed) the gloves; ygiene; donned new gloves; blood glucose; doffed the nd hygiene; took the and pulse. The RN donned to clean the equipment with blaced the equipment into the gloves still on. Doves, performed hand of gloves and removed the strat's wound. Keeping the RN sprayed the wound with and wiped it with gauze. The sperformed hand hygiene; applied antibiotic ointment; sing, secured with paper and gloves and performed and the bottle in the nursing bon); placed large open bag inped applicators in the and disposed in patient's vay somewhere in the b specimen bag; doubled and disposed in patient's vay somewhere in the control them be and doffed the control them be and zipped up The RN looked at Patient #4's control them control con | | 121 | | | |
| G 143 | 484.14(g) COORDIN | ATION OF PATIENT | G | 143 | | | |

| | | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) M A. BUI | | E CONSTRUCTION | (X3) DATE SURVEY COMPLETED | | |
|--------------------------|---|---|-------------------|-----|--|-------------------------------|----------------------------|--|
| | | 297130 | B. WIN | IG | | 07/17/2009 | | |
| | ROVIDER OR SUPPLIER | SERVICES, INC | • | 31 | EET ADDRESS, CITY, STATE, ZIP CODE 4 NEBRASKA AVENUE ENDERSON, NV 89015 | | | |
| (X4) ID PREFIX TAG | (EACH DEFICIENC | ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION) | ID PREF TAG | | PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPRO DEFICIENCY) | ILD BE | (X5) COMPLETION DATE | |
| G 143 | to ensure that their energetively and support the plan of care. This STANDARD is Based on record reving ensure all disciplines their efforts were coopsupported the goals of for 5 of 8 patients (Patient #2 Patient #2 Patient #2 Patient #2 was admit including abnormality diabetes mellitus, mathypertension. | ing services maintain liaison forts are coordinated in the objectives outlined in the objectives outlined in the objectives outlined in the maintained liaison to ensure radinated effectively and outlined in the plan of care atient #2, 5, 6, 7, 8). | G | 143 | DETICIENCE | | | |
| | to the proximal end of the upper arm). Patient #2's clinical revidence of communand CHHA regarding and progress. There was no docum | fell and sustained a fracture f the left humerus (top end ecord lacked documented feation among the SN, PT the patient's status, goals | | | | | | |

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIF | PLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED | |
|---|---|---|---------------------|--|-------------------------------|----------------------------|
| | | 297130 | B. WING | | 07/1 | 7/2009 |
| | OVIDER OR SUPPLIER S CARE HOME HEALTH | SERVICES, INC | 3 | REET ADDRESS, CITY, STATE, ZIP CODE 14 NEBRASKA AVENUE IENDERSON, NV 89015 | | |
| (X4) ID PREFIX TAG | (EACH DEFICIENC | ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION) | ID PREFIX TAG | PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPRO DEFICIENCY) | ILD BE | (X5) COMPLETION DATE |
| G 143 | her left arm. Patient #5 Patient #5 was admit including an open wo dependent diabetes rand chronic obstructi Patient #5's Plan of Offor the patient to be sand physical therapy There was no docum #5's clinical record to communicated with opatient's needs, goals Patient #6 Patient #6 was admit diagnoses including radiabetes mellitus, abit hypertension and Alz Patient #6 was being (SN), certified home in physical therapy (PT) Patient #6's clinical reevidence of communications | ted on 6/1/09 with diagnoses and of the leg, non-insulin mellitus, Parkinson's Disease we pulmonary disease. Care (POC) included orders seen by skilled nursing (SN) (PT). ented evidence in Patient indicate SN and PT see another regarding the seand progress. ted on 1/26/07 with non-insulin dependent normality of gait, heimer's Disease. seen by skilled nursing health aide (CHHA) and becord lacked documented ication between the SN, PT the patient's status, goals | G 143 | | | |
| | | non-insulin dependent | | | | |

| | | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION A. BUILDING | | | (X3) DATE SURVEY COMPLETED | | |
|--------------------------|---|--|---|-----|--|-------------------------------|----------------------------|--|
| | | 297130 | B. WIN | G | | 07/17/2009 | | |
| | ROVIDER OR SUPPLIER | SERVICES, INC | • | 314 | EET ADDRESS, CITY, STATE, ZIP CODE 4 NEBRASKA AVENUE ENDERSON, NV 89015 | | | |
| (X4) ID PREFIX TAG | (EACH DEFICIENC | TATEMENT OF DEFICIENCIES BY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION) | ID PREF TAG | | PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPRI DEFICIENCY) | ILD BE | (X5) COMPLETION DATE | |
| G 143 | weakness and hyper Patient #7's Plan of 0 skilled nursing (SN) a see the patient. Patient #7's clinical revidence of commun PT regarding the pat progress. Patient #8 Patient #8 was admit diagnoses including diabetes mellitus, hy obstructive pulmonar muscle weakness. As of 7/15/09, Patien skilled nursing (SN) a The clinical record la in the clinical record communicated with e #8's status, goals an 484.14(g) COORDIN SERVICES The clinical record or conferences establis | nbago, generalized muscle tension. Care included orders for and physical therapy (PT) to ecord lacked documented ication between the SN and ient's status, goals and et al. (a) the status of the sta | | 143 | | | | |
| | 1 | not met as evidenced by: and record review, the agency | | | | | | |

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE A. BUILDING | CONSTRUCTION | (X3) DATE SURVEY COMPLETED | |
|--|---|------------------------------|--|--------------------------------|----------------------------|
| | 297130 | B. WING | | 07/ | 17/2009 |
| NAME OF PROVIDER OR SUPPLIER MOTHER'S CARE HOME HEALTH | 1 SERVICES, INC | 314 | T ADDRESS, CITY, STATE, ZIP COD NEBRASKA AVENUE NDERSON, NV 89015 | E | |
| PREFIX (EACH DEFICIENT | TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION) | ID PREFIX TAG | PROVIDER'S PLAN OF C (EACH CORRECTIVE ACTIC CROSS-REFERENCED TO TH DEFICIENCY | ON SHOULD BE IE APPROPRIATE | (X5) COMPLETION DATE |
| regular basis to pror and coordination of (Patient #2, 3, 5, 6, 3) Findings include: Patient #2 Patient #2 was adminiculating abnormality diabetes mellitus, may hypertension. Documentation in the Patient #2 fell on 6/1 to the proximal end of the upper arm). As of 7/16/09, Patients killed nursing (SN), certified home health to the past two more patient #3 Patient #3 Patient #3 Patient #3 Patient #3 was adminication was adminicated evidence for the past two more patient #3 Patient #3 Patient #3 was adminicated evidence for the past two more patient #3 Patient #3 Patient #3 was adminicated evidence for the past two more patient #3 Patient #3 Patient #3 was adminicated evidence for the past two more patient #3 Patient #3 Patient #3 was adminicated evidence for the past two more patient #3 Patient #3 was adminicated evidence for the past two more patient #3 Patient #3 was adminicated evidence for the past two more patient #3 Patient #3 was adminicated evidence for the past two more patient #3 Patient #3 was adminicated evidence for the past two more patient #3 Patient #3 was adminicated evidence for the past two more patient #3 Patient #3 was adminicated evidence for the past two more patient #3 Patient #3 was adminicated evidence for the past two more patient #3 Patient #3 was adminicated evidence for the past two more patient #3 Patient #3 was adminicated evidence for the past two more patient #3 Patient #3 was adminicated evidence for the past two more patient #3 Patient #3 was adminicated evidence for the past two more patient #3 Patient #3 was adminicated evidence for the past two more patient #3 Patient #3 was adminicated evidence for the past two more patient #3 Patient #3 was adminicated evidence for the past two more patient #3 Patient #3 was adminicated evidence for the past two more patient #43 Patient #3 was adminicated evidence for the past two more patient #43 Patient #43 was adminicated evidence for the past two more patient #43 Patient #43 was adminicated evidence f | e conferences were held on a mote effective communication care for 6 of 8 patients 7, 8). Itted on 1/5/08 with diagnoses y of gait, insulin dependent accular degeneration and e clinical record revealed 1/09 and sustained a fracture of the left humerus (top end on t #2 was being seen by physical therapy (PT) and a n aide (CHHA). For Patient #2 lacked be of case conference notes withs. Itted on 4/21/07 with chronic obstructive and osteoarthrosis. Int #3 was being seen by and a certified home health | G 144 | | | |

| | | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) M A. BUI | | LE CONSTRUCTION | (X3) DATE SUF | | |
|--------------------------|--|--|-------------------|-----|--|---------------|----------------------------|--|
| | | 297130 | B. WIN | G | | 07/17/2009 | | |
| | OVIDER OR SUPPLIER | SERVICES, INC | • | 31 | EET ADDRESS, CITY, STATE, ZIP CODE 14 NEBRASKA AVENUE ENDERSON, NV 89015 | , | | |
| (X4) ID PREFIX TAG | (EACH DEFICIENC | ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL .SC IDENTIFYING INFORMATION) | ID PREF TAG | | PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPRO DEFICIENCY) | LD BE | (X5) COMPLETION DATE | |
| G 144 | insulin dependent dia peripheral vascular dia The clinical record for documented evidence for the past month. Patient #5 Patient #5 was admit including an open wo dependent diabetes rand chronic obstructivation obstructivation of the patient #5 was initially nursing (SN). On 6/1 evaluated the patient work evidence in Patient #5N and PT participated discuss Patient #5's rational patient #6 Patient #6 Patient #6 was admit diagnoses including rational diabetes mellitus, abra hypertension and Alzenal participated and patient #6 was admit diagnoses including rational patient #6 was admit diagno | ted on 4/15/09 with open wound on back, non-betes mellitus and sease. Patient #4 lacked e of case conference notes ted on 6/1/09 with diagnoses und of the leg, non-insulin nellitus, Parkinson's Disease we pulmonary disease. If being seen by skilled 19/09, physical therapy (PT) and obtained orders to treat. It was no documented 15's clinical record indicating the din case conference to needs, goals and progress. It was no documented 15's clinical record indicating the din case conference to needs, goals and progress. | G | 144 | | | | |
| | | e health aide (CHHA) and | | | | | | |

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | | IDENTIFICATION NUMBER: | | ULTIPL LDING | LE CONSTRUCTION | (X3) DATE SURVEY COMPLETED | |
|--|--|--|-------------------|-----------------|--|-------------------------------|----------------------------|
| | | 297130 | B. WIN | IG | | 07/1 | 7/2009 |
| | OVIDER OR SUPPLIER | H SERVICES, INC | , | 31 | EET ADDRESS, CITY, STATE, ZIP CODE 4 NEBRASKA AVENUE ENDERSON, NV 89015 | , | |
| (X4) ID PREFIX TAG | (EACH DEFICIEN | TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION) | ID PREF TAG | | PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) | | (X5) COMPLETION DATE |
| G 144 | Continued From pag | ge 11 | G | 144 | | | |
| | The clinical record for documented evidence for the past two more Patient #7 | ce of case conference notes | | | | | |
| | Patient #7 was adm diagnoses including | non-insulin dependent mbago, generalized muscle | | | | | |
| | Patient #7's was bei (SN) and physical th | ng seen by skilled nursing erapy (PT). | | | | | |
| | conferences in Patie | nented evidence of case ent #7's clinical record for the f 3/18/09 through 5/16/09. | | | | | |
| | Patient #8 | | | | | | |
| | diabetes mellitus, hy | non-insulin dependent | | | | | |
| | Patient #8 was being and physical therapy | g seen by skilled nursing (SN) y (PT) | | | | | |
| | | nented evidence of case ent #8's clinical record for the | | | | | |
| | Nursing (DON) indic held "every month day about the patier | ternoon, the Director of sated case conferences were . the LPN and I speak every hts" When asked if notes of were documented anywhere, | | | | | |

| STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA (X2) MUI IDENTIFICATION NUMBER: A. BUILLE | | | PLE CONSTRUCTION G | (X3) DATE SURVEY COMPLETED | | | |
|---|---|--|---------------------|--|---|-------|----------------------------|
| | | 297130 | B. WIN | IG_ | | 07/1 | 7/2009 |
| | OVIDER OR SUPPLIER | SERVICES, INC | • | 3 | REET ADDRESS, CITY, STATE, ZIP CODE B14 NEBRASKA AVENUE HENDERSON, NV 89015 | | |
| (X4) ID PREFIX TAG | (EACH DEFICIENC | ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION) | 1 | ID PROVIDER'S PLAN OF (PREFIX (EACH CORRECTIVE ACTI TAG CROSS-REFERENCED TO TI DEFICIENC' | | .D BE | (X5) COMPLETION DATE |
| G 144 | Continued From page | e 12 | G | 144 | | | |
| G 158 | the DON replied, "No 484.18 ACCEPTANC MED SUPER | ." E OF PATIENTS, POC, | G | 158 | | | |
| | | n plan of care established wed by a doctor of medicine, ric medicine. | | | | | |
| | Based on record revided | not met as evidenced by: ew, the facility failed to followed the physician's ents (Patient #2, 3, 4, 5, 6, 7). | | | | | |
| | Findings include: | | | | | | |
| | Patient #2 | | | | | | |
| | including abnormality diabetes mellitus, ma hypertension. On 6/1 | ted on 1/5/08 with diagnoses of gait, insulin dependent cular degeneration and 1/09, the patient fell and o the proximal end of the left the upper arm). | | | | | |
| | for skilled nursing (SI times a day for seven | are (POC) included orders N) to see the patient two days; six times a week for ee times a week for one | | | | | |
| | clinical record, SN sa on 6/17/09, 6/18/09 a record lacked docum- physician was notified patient twice a day fo clinical record lacked | umentation in Patient #2's w the patient one time a day and 6/19/09. The clinical ented evidence the d SN was not seeing the r three days in a row. The a physician's order to of SN visits by three for the | | | | | |

| | | | (X3) DATE SUI COMPLET | | | | |
|--------------------------|--|--|--------------------------|--|--|--------|----------------------------|
| | | 297130 | B. WIN | IG | | 07/1 | 7/2009 |
| | ROVIDER OR SUPPLIER S CARE HOME HEALTH | SERVICES, INC | · | STREET ADDRESS, CITY, STATE, ZIP O 314 NEBRASKA AVENUE HENDERSON, NV 89015 | | | |
| (X4) ID PREFIX TAG | (EACH DEFICIENC | ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION) | ID PREF TAG | | PROVIDER'S PLAN OF CORREC (EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPR DEFICIENCY) | JLD BE | (X5) COMPLETION DATE |
| G 158 | "Soma 350 milligram mouth three times a Patient #2 indicated every day. Patient #3 Patient #3 Patient #3 was admit diagnoses including pulmonary disease a The Plan of Care (PC skilled nursing (SN) tweek for one week a eight weeks for the contrough 8/7/09. Documentation in Parevealed the patient of first week of the certithrough 8/7/09. The clinical record lathe SN notified the plants with the SN notified the plants with the SN notified the plants with the SN visiting the SN visiting week of the certithrough 8/7/09. Patient #4 Patient #4 Patient #4 was admit diagnoses including states week and states week and states with the certithrough 8/7/09. | rders for Patient #2 to take is per tablet one tablet by day PRN (as needed)." she routinely took one tablet ited on 4/21/07 with chronic obstructive ind osteoarthrosis. OC) included orders for o see Patient #3 two times a not then, one time a week for ertification period of 6/9/09 tient #3's clinical record was seen one time during the fication period 6/9/09 cked documented evidence invision regarding the nical record lacked in a physician's order to its from two to one during the fication period 6/9/09 ted on 4/15/09 with an open wound to the upper pendent diabetes mellitus and | G | 158 | | | |

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | | (X2) M A. BUI | | PLE CONSTRUCTION 3 | (X3) DATE SURVEY COMPLETED | | |
|--|--|---|--------|---|---|-------|----------------------------|
| | | 297130 | B. WIN | IG | | 07/1 | 7/2009 |
| | OVIDER OR SUPPLIER | SERVICES, INC | • | 3 | REET ADDRESS, CITY, STATE, ZIP CODE 114 NEBRASKA AVENUE HENDERSON, NV 89015 | • | |
| (X4) ID PREFIX TAG | (EACH DEFICIENC) | ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION) | I | ID PROVIDER'S PLAN PREFIX (EACH CORRECTIVE. TAG CROSS-REFERENCED T DEFICI | | LD BE | (X5) COMPLETION DATE |
| G 158 | Continued From page | e 14 | G | 158 | | | |
| | for skilled nursing (SN day for care to the wood ay for care to hold the visits for 1. Patient #4's clinical redocumented evidence was notified of the mit. On 7/15/09 in the moshe had traveled out reunion for seven day | ecord did not contain e indicating the physician | | | | | |
| | patient indicated there Patient #5 | e was none. | | | | | |
| | Patient #5 was admittincluding an open wo dependent diabetes r | ted on 6/1/09 with diagnoses und of the leg, non-insulin nellitus, Parkinson ' s obstructive pulmonary | | | | | |
| | for a certified home h | care (POC) included orders ealth aide (CHHA) to see a week for nine weeks for nce. | | | | | |
| | visit notes. The clinic | ecord did not contain CHHA al record did not include a ancel the CHHA visits. | | | | | |
| | Patient #6 | | | | | | |

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | | (X2) M A. BUI | | PLE CONSTRUCTION G | (X3) DATE SURVEY COMPLETED | | |
|--|--|---|-------------------|--|---|---------|----------------------------|
| | | 297130 | B. WIN | IG_ | | 07/1 | 7/2009 |
| | ROVIDER OR SUPPLIER S CARE HOME HEALTH | SERVICES, INC | • | STREET ADDRESS, CITY, STATE, ZIF 314 NEBRASKA AVENUE HENDERSON, NV 89015 | | • | |
| (X4) ID PREFIX TAG | (EACH DEFICIENC | ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION) | ID PREF TAG | | PROVIDER'S PLAN OF CORRE (EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE APP DEFICIENCY) | OULD BE | (X5) COMPLETION DATE |
| G 158 | diabetes mellitus, abin hypertension and Alzer Patient #6's clinical reskilled nursing (SN) to 14 days; then threweeks; and then, two weeks, for the certific (5/27/09 through 7/25 Documentation in Parevealed SN saw the and then, did not see row. A physician's order diclinical record read, effective 6/20/09. SN saw Patient #6 the clinical record lacked seeing the patient aft order was fulfilled with Patient #6's clinical recertified nursing assist patient four times a war a week for three weeks for the weeks (5/27/09 through According to docume the CNA saw Patient week; two times a week in the week; two times a week in the week; two times a week in the conditions and the conditions are the conditions are the conditions and the conditions are th | ted on 1/26/07 with non-insulin dependent normality of gait, heimer's Disease. ecord contained orders for o see the patient every day the times a week for three times a week for four ation period of nine weeks 6/09). Itient #6's clinical record, patient seven days in a row the patient for five days in a ated 6/19/09 in Patient #6's SN daily for one week, irteen days in a row. The orders for SN to continue the physician's 6/19/09 in the visit on 6/26/09. ecord contained orders for a stant (CNA) to see the reek for one week; five times ks; and three times a week certification period of nine | G | 158 | | | |

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | | (X2) M A. BUI | | IPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED | | |
|--|---|--|-------------------|--|--|--------|----------------------------|
| | | 297130 | B. WIN | 1G _ | | 07/1 | 7/2009 |
| | OVIDER OR SUPPLIER | SERVICES, INC | | STREET ADDRESS, CITY, STATE, ZIP 314 NEBRASKA AVENUE HENDERSON, NV 89015 | | · | |
| (X4) ID PREFIX TAG | (EACH DEFICIENC | ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION) | ID PREF TAG | IX | PROVIDER'S PLAN OF CORREC (EACH CORRECTIVE ACTION SHOI CROSS-REFERENCED TO THE APPR DEFICIENCY) | JLD BE | (X5) COMPLETION DATE |
| G 158 | physical therapy (PT) week; and then, three weeks. According to docume PT saw Patient #6 or and then three times 7/16/09, the clinical rethe last three weeks at Patient #7 Patient #7 Patient #7 was admit diagnoses including rediabetes mellitus, lun weakness and hyper Patient #7's Plan of Comparison of the same week for one week for seven week Patient #7's clinical revidence SN saw the 4/6, 4/13 and 4/20/03 3/18/09 through 5/16. Patient #7's clinical reto see the patient two and then, one time a patient's clinical recoveridence SN saw the 6/28 and 7/5/09 for the 5/17/09 through 7/15. | ecord contained orders for one time a week for one et times a week for four entation in the clinical record, the time a week for one week; a week for one week. On ecord lacked PT notes for as ordered. Ited on 3/18/09 with mon-insulin dependent mbago, generalized muscle tension. Care (POC) included orders (POC) included orders (POC) included orders (POC) week and then, one time as s. Ecord lacked documented (Poc) included orders (POC) | | 158 | | | |
| | Drugs and treatments | s are administered by | | | | | |

| STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER: | | (X2) M A. BUII | | PLE CONSTRUCTION G | (X3) DATE SURVEY COMPLETED | | |
|---|---|---|----------|--|---|--------|----------------------------|
| | | 297130 | B. WIN | G | | 07/1 | 7/2009 |
| | ROVIDER OR SUPPLIER | SERVICES, INC | , | 3 | REET ADDRESS, CITY, STATE, ZIP CODE 314 NEBRASKA AVENUE HENDERSON, NV 89015 | , | ., |
| (X4) ID PREFIX TAG | (EACH DEFICIENC | ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION) | 1 | ID PROVIDER'S PLAN OF PREFIX (EACH CORRECTIVE ACT TAG CROSS-REFERENCED TO T DEFICIENCE | | ILD BE | (X5) COMPLETION DATE |
| G 165 | agency staff only as of agency staff only as of agency staff only as of Based on record reviet the agency failed to eadministered, and 2) only as prescribed by patients (Patients #1, Findings include: Patient #1 Patient #1 was admit including insulin deperance of the pancrea and chronic obstruction. On the skilled nursing 4/2/09, the licensed produmented, " Pt (provided from the clinical record late Benadryl. On the SNVN dated 4 Patient #1 had a "5 composite to the composite of the present to R (right) for Duoderm to avoid any | and the met as evidenced by: ew and document review, ensure 1) medications were wound care was provided a physician for 7 of 8 2, 3, 4, 6, 7, 8). The matter of the metal of | G | 165 | | | |
| | Patient #1's right hee | OC) did not include orders for I pressure ulcer. There were ers in the clinical record for | | | | | |

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIP | LE CONSTRUCTION | (X3) DATE SURVEY COMPLETED | |
|--|--|--|---------------------|---|-------------------------------|----------------------------|
| | | 297130 | B. WING | | 07/· | 17/2009 |
| | ROVIDER OR SUPPLIER | SERVICES, INC | 31 | EET ADDRESS, CITY, STATE, ZIP CODE 14 NEBRASKA AVENUE ENDERSON, NV 89015 | | |
| (X4) ID PREFIX TAG | (EACH DEFICIENC | ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION) | ID PREFIX TAG | PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) | | (X5) COMPLETION DATE |
| G 165 | On 7/28/09 at 10:35 a "Normal saline was use always use normal saline was use always use normal saline was used always use normal saline was used always use normal saline was used always use normal saline was | AM, the LPN explained, sed to cleanse the wound - I aline." of durable medical ies, Patient #1 was on of oxygen (liters per tient was to receive it and asal cannula) was not. There were no in the clinical record for AM during a telephone in the clinical record for AM during a telephone in the clinical record for N indicated Patient #1 was as needed) basis. N dated 4/6/09, the LPN azepam 0.5 mg PO at HS ag at HS." Lorazepam and listed on the POC. Cked a physician's order for azapine. N dated 4/10/09, the LPN (discontinued) HS started on Ambien 6.25 mg at bedtime." | G 165 | | | |

| | | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIF | PLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED | |
|--------------------------|--|---|---------------------|---|-------------------------------|----------------------------|
| | | 297130 | B. WING | | 07/1 | 7/2009 |
| | OVIDER OR SUPPLIER | SERVICES, INC | 3 | REET ADDRESS, CITY, STATE, ZIP CODE B14 NEBRASKA AVENUE HENDERSON, NV 89015 | | |
| (X4) ID PREFIX TAG | (EACH DEFICIENC | ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION) | ID PREFIX TAG | PROVIDER'S PLAN OF COR (EACH CORRECTIVE ACTION S CROSS-REFERENCED TO THE A DEFICIENCY) | SHOULD BE | (X5) COMPLETION DATE |
| G 165 | to the proximal end of of the upper arm). The POC included or "Soma 350 milligram mouth three times a Patient #2 indicated severy day. Patient #2's Plan of Of for the certified nursing the patient one time at times a week for two three weeks; and one beginning the week of Documentation in Parevealed the CNA sat week for three weeks. Patient #3 Patient #3 was admitted diagnoses including of pulmonary disease at Patient #3 revealed so Mirtazapine 30 milligued bedtime for "about a listed on the Plan of Of certification period of Mirtazapine was not Profile (PMP). | ders for Patient #2 to take sper tablet one tablet by day PRN (as needed)." she routinely took one tablet care (POC) included orders a sassistant (CNA) to see a week for one week; three weeks; two times a week for a time a week for two weeks, if 6/14/09. Itient #2's clinical record with patient three times a st. Ited on 4/21/07 with chronic obstructive and osteoarthrosis. The had been taking trans per tablet one tablet at year." Mirtazapine was not | G 165 | | | |

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | | (X2) M A. BUI | | PLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED | | |
|---|---|--|-------------------|------------------|--|------------|----------------------------|
| | | 297130 | B. WIN | IG | | 07/17/2009 | |
| | OVIDER OR SUPPLIER S CARE HOME HEALTH | SERVICES, INC | • | 3. | EET ADDRESS, CITY, STATE, ZIP CODE 14 NEBRASKA AVENUE IENDERSON, NV 89015 | | |
| (X4) ID PREFIX TAG | (EACH DEFICIENC | ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION) | ID PREF TAG | | PROVIDER'S PLAN OF CORREC (EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPR DEFICIENCY) | JLD BE | (X5) COMPLETION DATE |
| G 165 | certification period of These vitamins were Patient #3 retrieved a refrigerator. The bott Codeine 6.25 milligrateaspoon to be taken hours as needed for was not listed on the Patient #4 Patient #4 was admit diagnoses including a back, non-insulin depand peripheral vascu On 7/15/09 around 1 in response to being was taking at that tim drawer, revealing sexprescription medication. Patient #4's drawer of that were not include and the patient medic prescription was Detrwith instructions to take day. The second prescript milligrams per tablet, tablet by mouth every medications was 6/10. | not listed on the POC for the 6/9/09 through 8/7/09. not listed on the PMP. In prescription bottle from the ele contained Phenergan with ms/10 milligrams one by mouth every four to six cough. This medication POC and the PMP. Ited on 4/15/09 with an open wound to the upper pendent diabetes mellitus lar disease. 1:00 AM during a home visit, asked what medications shee, Patient #4 opened a veral containers of ons. Ontained two prescriptions and on the Plan of Care (POC) cation profile (PMP). One collated the plan of | G | 165 | | | |

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPL A. BUILDING | LE CONSTRUCTION | (X3) DATE SURVEY COMPLETED | |
|---|--|--|-----------------------------|---|-------------------------------|----------------------------|
| | | 297130 | B. WING | | 07/1 | 17/2009 |
| | ROVIDER OR SUPPLIER S CARE HOME HEALTH | SERVICES, INC | 31 | EET ADDRESS, CITY, STATE, ZIP CODE 4 NEBRASKA AVENUE ENDERSON, NV 89015 | | |
| (X4) ID PREFIX TAG | (EACH DEFICIENC | ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION) | ID PREFIX TAG | PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) | | (X5) COMPLETION DATE |
| G 165 | Patient #4 had a bott 750 milligrams per ta she took one "once in Patient #4 had a bott 500 milligrams per ta the patient was to tak four hours as needed indicated she took "a sleep." Patient #6 Patient #6 was admit diagnoses including r diabetes mellitus, abin hypertension and Alz According to the 60 diagnoses including r diabetes mellitus, abin hypertension and Alz According to the 60 diagnoses on the lower lesustained on April 4, The Plan of Care (Pocertification period of not include wound caright heel pressure so Patient #6's clinical re Nursing (SN) notes diand 6/8, 6/10, 6/12, 6 revealed the SN "cl heel with NS (normal | these two medications in the rd. e of over-the-counter Tums blet. The patient indicated a awhile." e of extra strength Tylenol blet. According to the POC, the two tablets by mouth every for pain. The patient average of one a week for the average of one a week for the average of one a week for the previous attent #6 developed a right heel while wearing a g for a fracture knee 2009. OC) prepared for the 5/27/09 through 7/25/09 did re orders for Patient #6's ore. ecord contained Skilled atted 5/27/09 through 6/2/09 /15 and 6/17/09 which eaned pressure wound right saline) and Hydrogel apply sing), 4" Kling (long gauze) | G 165 | | | |

| STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER: | | | (X2) M A. BUI | | PLE CONSTRUCTION G | (X3) DATE SURVEY COMPLETED | | |
|---|---|---|-------------------|--|--|-------------------------------|----------------------------|--|
| | | 297130 | B. WIN | IG | | 07/1 | 7/2009 | |
| | OVIDER OR SUPPLIER | SERVICES, INC | • | STREET ADDRESS, CITY, STATE, ZIP O 314 NEBRASKA AVENUE HENDERSON, NV 89015 | | • | | |
| (X4) ID PREFIX TAG | (EACH DEFICIENC) | ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL .SC IDENTIFYING INFORMATION) | ID PREF TAG | IX | PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPRO DEFICIENCY) | LD BE | (X5) COMPLETION DATE | |
| G 165 | Continued From page | 22 | G | 165 | | | | |
| | order dated 6/19/09 v heel wound daily cove The clinical record lace wound care after the In addition to the daily through 6/27/09, Patic contained daily SN no 7/2/09 for a total of fiv physician ordered on Patient #7 Patient #7 was admitt diagnoses including r diabetes mellitus, lum weakness and hypert Patient #7's Plan of C for skilled nursing (SN times a week for one week for seven week certification period from 3/18/09 through Patient #7's clinical re 3/18, 3/19 and 3/20/0 On 7/16/09 in the mo explained the visit on needed) because Pat "fainted last night." Patient #7's clinical re order for the PRN vis | ted on 3/18/09 with non-insulin dependent abago, generalized muscle ension. Eare (POC) included orders (POC) included orders (POC) to see the patient two week and then, one time a sof the (nine week) 5/16/09. Ecord contained SN notes for 9. Trining, the director of nursing 3/20/09 was a PRN (ascient #7 called and said she | | | | | | |

| STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION AND PLAN OF CORRECTION IDENTIFICATION NUMBER: A. BUILDING | | | (X3) DATE SURVEY COMPLETED | | | | |
|---|---|---|--|-----|---|------|--------|
| | | 297130 | B. WIN | IG_ | | 07/1 | 7/2009 |
| | OVIDER OR SUPPLIER | SERVICES, INC | • | ; | REET ADDRESS, CITY, STATE, ZIP CODE 314 NEBRASKA AVENUE HENDERSON, NV 89015 | | |
| (X4) ID PREFIX TAG | (EACH DEFICIENC | ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION) | CEDED BY FULL PREFIX (EACH CORRECTIVE ACTION SHOULD BE | | (X5) COMPLETION DATE | | |
| G 165 | clinical record lacked two extra visits made and the one extra visits 5/11/09. Patient #8 Patient #8 was admit diagnoses including r diabetes mellitus, hypobstructive pulmonar muscle weakness. Patient #8's clinical reskilled nursing (SN) to week for one week at eight weeks. On 5/23/09, Patient # care facility. On 5/29 of care (ROC). Patient #8's ROC included for six weeks. According to docume | 5/8 and 5/15/09. The a physician's order for the during the week of 5/4/09 t during the week of ted on 7/31/07 with an-insulin dependent | | 165 | | | |
| G 186 | week for one week at for three weeks (up to 484.32 THERAPY SE The qualified therapis evaluating the patient | - · · | G | 186 | | | |
| | necessary.) | | | | | | |

| STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER: | | A. BUI | | PLE CONSTRUCTION G | (X3) DATE SURVEY COMPLETED | | |
|---|--|---|-------------------|---------------------|--|-------|----------------------------|
| | | 297130 | B. WIN | IG | ······································ | 07/1 | 7/2009 |
| | OVIDER OR SUPPLIER | SERVICES, INC | | 3 | REET ADDRESS, CITY, STATE, ZIP CODE 314 NEBRASKA AVENUE HENDERSON, NV 89015 | | |
| (X4) ID PREFIX TAG | (EACH DEFICIENC | TATEMENT OF DEFICIENCIES BY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION) | ID PREF TAG | | PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPRO DEFICIENCY) | LD BE | (X5) COMPLETION DATE |
| G 186 | Continued From pag | e 24 | G | 186 | | | |
| G 224 | Based on record reviensure the physical tand revised a plan of during the seven were period for 1 of 8 paties. Findings include: Patient #8 Patient #8 was admit diagnoses including diabetes mellitus, hy obstructive pulmonar muscle weakness. The 6/4/09 physical tander Patient #8 indicated times a week for eight on 6/4/09, Patient #8 5/21/09 through 7/19 remaining. There was revising the duration weeks. 484.36(c)(1) ASSIGN HOME HEALTH AID Written patient care in health aide must be in nurse or other appropresponsible for the signal and revising the signal and revisions weeks. | tted on 7/31/07 with non-insulin dependent pertension, chronic ry disease and generalized therapy (PT) evaluation for PT would see the patient two nt weeks. B's certification period of //09 had seven weeks as no supplemental order of PT visits to be for seven | G | 224 | | | |
| | | not met as evidenced by: and record review, the agency | | | | | |

| | TATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | | (X2) MI | | LE CONSTRUCTION | (X3) DATE SURVEY COMPLETED | |
|--------------------------|--|--|--------------------|-----|--|----------------------------|----------------------------|
| | | 297130 | B. WIN | G | | 07/1 | 7/2009 |
| | ROVIDER OR SUPPLIER | SERVICES, INC | | 31 | EET ADDRESS, CITY, STATE, ZIP CODE 4 NEBRASKA AVENUE ENDERSON, NV 89015 | , | |
| (X4) ID PREFIX TAG | (EACH DEFICIENC) | ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION) | ID PREFI TAG | | PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPRO DEFICIENCY) | LD BE | (X5) COMPLETION DATE |
| G 224 | failed to ensure the recomplete and specific certified home health for 3 of 8 patients (Parameter Findings include: Patient #2 Patient #2 was admittincluding abnormality diabetes mellitus, manypertension. On 6/1/09, the patient fracture to the proxim (top end of the upper Patient #2 was being health aide (CHHA) for care and activities of fractured humerus and arm immobile. The CHHA Assignment include instructions repatient to wear the slip Patient #3 Patient #3 Patient #3 Patient #3 was admitted diagnoses including of pulmonary disease and Patient #3 was being health aide (CHHA) of the complete was a second pulmonary disease and Patient #3 was being health aide (CHHA) of the complete was a second pulmonary disease and Patient #3 was being health aide (CHHA) of the complete was a second pulmonary disease and patient #3 was being health aide (CHHA) of the complete was a second pulmonary disease and patient #3 was being health aide (CHHA) of the complete was a second pulmonary disease and pulm | egistered nurse prepared written instructions for the aide to follow while caring stients #2, 3, 6). Ted on 1/5/08 with diagnoses of gait, insulin dependent cular degeneration and the fell and sustained a all end of the left humerus arm). Seen by the certified home or assistance with personal daily living secondary to the did the need to keep the left arm. The for Patient #2 did not be regarding the need for the need for the need for the need on her left arm. | G | 224 | | | |
| | accitcoping. | | | | | | |

| I ' ' | | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION A. BUILDING | | | (X3) DATE SURVEY COMPLETED | |
|--------------------------|---|--|---|-----|--|-------------------------------|----------------------------|
| | | 297130 | B. WING | | | 07/17/2009 | |
| | OVIDER OR SUPPLIER | SERVICES, INC | • | 31 | EET ADDRESS, CITY, STATE, ZIP CODE 4 NEBRASKA AVENUE ENDERSON, NV 89015 | | |
| (X4) ID PREFIX TAG | (EACH DEFICIENC) | ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION) | ID PREFI TAG | | PROVIDER'S PLAN OF CORRECTI (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPRO DEFICIENCY) | D BE | (X5) COMPLETION DATE |
| G 224 | the CHHA was to assassist bath - chair." The specify when a partice of the Assignment did record to call the registered each visit and obtain method to use for bath the CHHA Assignment include instructions for patient's blood presson patient's blood presson Patient #6 Patient #6 was admitted diagnoses including rediabetes mellitus, about hypertension and Alzer Patient #6's CHHA Assignment and Alzer Patient #6's clinical resperformed a bed bath for the patient. Documentation on the notes in Patient #6's clinical resperformed a bed bath for the patient. | ant for Patient #3 indicated sist with a "tub bath/shower, The Assignment did not ular method was to be used. The Assignment did not ular method was to be used. The indicate the CHHA was nurse with a status report instructions regarding which thing the patient. The for Patient #3 did not for the CHHA to obtain the or the CHHA to obtain the or the certification period of the certification pe | G | 224 | | | |
| G 229 | 484.36(d)(2) SUPER' The registered nurse | VISION (or another professional | G: | 229 | | | |

| | STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | | (X2) M A. BUII | | PLE CONSTRUCTION G | (X3) DATE SURVEY COMPLETED | |
|--------------------------|--|--|-------------------|-----|--|----------------------------|----------------------------|
| | | 297130 | B. WIN | IG_ | | 07/1 | 7/2009 |
| | OVIDER OR SUPPLIER | SERVICES, INC | | : | REET ADDRESS, CITY, STATE, ZIP CODE 314 NEBRASKA AVENUE HENDERSON, NV 89015 | <u> </u> | 77200 |
| (X4) ID PREFIX TAG | (EACH DEFICIENC | ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION) | ID PREF TAG | | PROVIDER'S PLAN OF CORREC (EACH CORRECTIVE ACTION SHOI CROSS-REFERENCED TO THE APPR DEFICIENCY) | JLD BE | (X5) COMPLETION DATE |
| G 229 | described in paragrap must make an on-site no less frequently tha | oh (d)(1) of this section) visit to the patient's home | G | 229 | | | |
| | Based on record reviethe agency failed to ecompleted an on-site days or less with the | ew and document review, nsure the registered nurse supervisory visit every 14 certified home health aide f 8 patients (Patients #2, 3, | | | | | |
| | Findings include: Patient #2 | | | | | | |
| | including abnormality | ted on 1/5/08 with diagnoses of gait, insulin dependent cular degeneration and | | | | | |
| | On 6/1/09, the patien fractured to the proxin (top end of the upper | nal end of the left humerus | | | | | |
| | | seen by a certified home of assist with personal care living. | | | | | |
| | CHHA for Patient #2 clinical record include note, dated 6/15/09 a nurse (RN). The clini | e of CNA supervisory visits | | | | | |

| | STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | | (X2) M A. BUI | | PLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED | | |
|--------------------------|--|---|-------------------|-----|--|----------------------------|----------------------------|--|
| | | 297130 | B. WIN | IG | | 07/17/2009 | | |
| | OVIDER OR SUPPLIER | SERVICES, INC | • | 3 | REET ADDRESS, CITY, STATE, ZIP CODE 114 NEBRASKA AVENUE HENDERSON, NV 89015 | , | | |
| (X4) ID PREFIX TAG | (EACH DEFICIENC | ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION) | ID PREF TAG | | PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPRO DEFICIENCY) | LD BE | (X5) COMPLETION DATE | |
| G 229 | Continued From page Patient #3 | e 28 | G | 229 | | | | |
| | Patient #3 was admit diagnoses including of pulmonary disease a | chronic obstructive | | | | | | |
| | _ | seen by the certified home assist with a shower once | | | | | | |
| | evidence of a CHHA | ecord lacked documented supervisory visit by the ast every 14 days from 9. | | | | | | |
| | Patient #6 | | | | | | | |
| | Patient #6 was admit diagnoses including r diabetes mellitus, abi hypertension and Alz | non-insulin dependent normality of gait, | | | | | | |
| | evidence of a CHHA | ecord lacked documented supervisory visit by the ast every 14 days from 09. | | | | | | |
| | Policies and Procedu | ncy's 2006 MED-PASS, Inc. res Manual for Home Health h aide supervisory visits will ry 14 days." | | | | | | |
| G 236 | 484.48 CLINICAL RE | CORDS | G | 236 | | | | |
| | current findings in acc professional standard patient receiving hom addition to the plan o | aining pertinent past and cordance with accepted is is maintained for every le health services. In f care, the record contains g information; name of | | | | | | |

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | ` ' | (X2) MULTIPLE CONSTRUCTION A. BUILDING | | (X3) DATE SURVEY COMPLETED | |
|---|--|---|-------------------|---|--|-------------------------------|----------------------------|
| | | 297130 | B. WIN | B. WING | | 07/17/2009 | |
| | OVIDER OR SUPPLIER | SERVICES, INC | | 3 | REET ADDRESS, CITY, STATE, ZIP CODE 14 NEBRASKA AVENUE HENDERSON, NV 89015 | | |
| (X4) ID PREFIX TAG | (EACH DEFICIENC) | ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION) | ID PREF TAG | | PROVIDER'S PLAN OF CORRECTI (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPRO DEFICIENCY) | .D BE | (X5) COMPLETION DATE |
| G 236 | orders; signed and da notes; copies of sumr | e 29 ry, treatment, and activity ated clinical and progress mary reports sent to the and a discharge summary. | G | 236 | | | |
| | Based on record revie | not met as evidenced by: ew, the agency failed to s contained the medical ents (Patient #5). | | | | | |
| | including an open wo dependent diabetes n | ted on 6/1/09 with diagnoses und of the leg, non-insulin nellitus, Parkinson's Disease we pulmonary disease. | | | | | |
| G 337 | evidence of the patier 484.55(c) DRUG REC The comprehensive a | - | G | 337 | | | |
| | using in order to ident effects and drug reac drug therapy, significa | tify any potential adverse tions, including ineffective ant side effects, significant blicate drug therapy, and | | | | | |
| | Based on interview, review, the agency fa record reflected curre Patient Medication Pr | not met as evidenced by: ecord review and policy iled to 1) ensure the clinical ent medications and 2) the rofile was updated each time ons occurred for 4 of 8 2, 3, 4). | | | | | |

| STATEMENT OF DEFICIENCIES (X1 AND PLAN OF CORRECTION |) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULT | PLE CONSTRUCTION G | (X3) DATE SL COMPLE | | |
|---|--|---------------------|--|----------------------------------|----------------------------|--|
| | 297130 | B. WING _ | | 07/17/2009 | | |
| NAME OF PROVIDER OR SUPPLIER MOTHER'S CARE HOME HEALTH SEI | RVICES, INC | | REET ADDRESS, CITY, STATE, ZIP CO 314 NEBRASKA AVENUE HENDERSON, NV 89015 | • | | |
| PREFIX (EACH DEFICIENCY MU | MENT OF DEFICIENCIES JST BE PRECEDED BY FULL IDENTIFYING INFORMATION) | ID PREFIX TAG | PROVIDER'S PLAN OF (EACH CORRECTIVE ACT CROSS-REFERENCED TO T DEFICIENC | TON SHOULD BE THE APPROPRIATE | (X5) COMPLETION DATE | |
| Findings include: Patient #1 Patient #1 was admitted including insulin depende cancer of the pancreas, and chronic obstructive patient #1's clinical reconnursing visit note (SNVN) the licensed practical numbers of the patient was given relief" Benadryl was not listed of medication profile (PMP) lacked documented evide order for Benadryl. The indicate Benadryl was given according to the list of dequipment and supplies, oxygen. The number of the patient was to receive delivery (nasal cannula) included on the POC and On 7/28/09 at 10:35 AM, Patient #1 was on oxyge basis. On Patient #1's SNVN dedocumented, " Lorazer and Mirtazepine 15 mg are patient #1's PMP did not Mirtazepine. | on 4/1/09 with diagnoses ent diabetes mellitus, macular degeneration oulmonary disease. Indiction of the diagnoses ent diabetes mellitus, macular degeneration oulmonary disease. Indiction of the diagnose ent dia | G 337 | | | | |

| STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | | (X2) M A. BUI | | LE CONSTRUCTION | (X3) DATE SURVEY COMPLETED | | | |
|--|---|---|-------------------|-----------------|--|------------|----------------------------|--|
| | | 297130 | B. WIN | IG | | 07/17/2009 | | |
| | OVIDER OR SUPPLIER | SERVICES, INC | • | 31 | EET ADDRESS, CITY, STATE, ZIP CODE 14 NEBRASKA AVENUE ENDERSON, NV 89015 | | | |
| (X4) ID PREFIX TAG | (EACH DEFICIENC | ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION) | ID PREF TAG | | PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPRO DEFICIENCY) | LD BE | (X5) COMPLETION DATE | |
| G 337 | documented, " DC'ol Lorazepam & pt was one tablet by mouth a The PMP was not up discontinuation of the initiation of the Ambie Patient #2 Patient #2 Was admit including abnormality diabetes mellitus, manypertension. On 6/3 sustained a fractured left humerus (top end left humerus (top end left humerus (top end left humerus) (top end left h | N dated 4/10/09, the LPN d (discontinued) HS started on Ambien 6.25 mg at bedtime." dated to reflect the Lorazepam and the en. ted on 1/5/08 with diagnoses of gait, insulin dependent cular degeneration and 1/09, the patient fell and to the proximal end of the lof the upper arm). In of Care (POC), Patient #2 yburide/Metformin 5/500 one tablet by mouth twice a ne afternoon during a home bottle label read, 5/500 milligrams per tablet twice a day." ders for Patient #2 to take is per tablet one tablet by day PRN (as needed)." she routinely took one Soma | G | 337 | | | | |

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MUL A. BUILD | TIPLE CONSTRUCTION | | (X3) DATE SURVEY COMPLETED | |
|--|--|---|----------------------|--|--------------------------------------|-------------------------------|--|
| | | 297130 | B. WING | | 07/ | 17/2009 | |
| NAME OF PROVIDER OR SUPP | | SERVICES, INC | 5 | STREET ADDRESS, CITY, STATE, ZIP (314 NEBRASKA AVENUE HENDERSON, NV 89015 | CODE | | |
| PREFIX (EACH D | EFICIENC | ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION) | ID PREFIX TAG | PROVIDER'S PLAN ((EACH CORRECTIVE A CROSS-REFERENCED TO DEFICIE | CTION SHOULD BE O THE APPROPRIATE | (X5) COMPLETION DATE | |
| diagnoses ind pulmonary dispulmonary dispulm | as admit cluding of sease and the moought out time. I wealed so milligratime for the ceriod of wealed stamin C hese vitt for the ceriod of y. The d, "Vitar y for earns the reference of the ceriod o | ted on 4/21/07 with chronic obstructive and osteoarthrosis. rning during a home visit, at the medications she was the had been taking tams per tablet one tablet by "about a year." Mirtazapine Plan of Care (orders) for the 6/9/09 through 8/7/09. the was taking Vitamin A & D of Vitamin E and Vitamin A tamins were not listed on the pertification period of 6/9/09 Medication Profile had an mins." There was no ch vitamin and the quency, etc. In bottle of prescription cough frigerator. This bottle of eine was not listed on the Patient Medication Profile. | G 33 | 37 | | | |

| STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER: | | A. BUI | | PLE CONSTRUCTION G | (X3) DATE SURVEY COMPLETED | | |
|---|--|---|-------------------|---------------------|--|--------|----------------------------|
| | | 297130 | B. WIN | IG | | 07/1 | 7/2009 |
| | ROVIDER OR SUPPLIER S CARE HOME HEALTH | SERVICES, INC | • | 3 | REET ADDRESS, CITY, STATE, ZIP CODE 314 NEBRASKA AVENUE HENDERSON, NV 89015 | | |
| (X4) ID PREFIX TAG | (EACH DEFICIENC | TATEMENT OF DEFICIENCIES BY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION) | ID PREF TAG | | PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPRO DEFICIENCY) | ILD BE | (X5) COMPLETION DATE |
| G 337 | 4/15/09, included Alt to the wound every of the Patient Medication. On 6/10/09 during a Patient #4 opened a Inside the drawer was tablet to be taken by LA was not listed on Patient #4's medicate prescription bottle of tablet to be taken by bottle contained sever indicated she did not for. Avelox was not Patient #4's medicated the counter bottle of patient indicated she a while." Tums was was no physician's of According to the age Profile, from Policies Home Health Care 2 (revised 2006), " 4 add all new/changed medication profile. It medications will be contained and the patient indicated she are profile, from Policies Home Health Care 2 (revised 2006), " 4 add all new/changed medication profile. It medications will be contained and the patient indicated she are patient indicated she | Care Medications, dated abax ointment to be applied lay. Altabax was not listed on on Profile (PMP). Thome visit around noon, drawer of medications. Is Detrol LA 4 milligrams one mouth once a day. Detrol the patient's PMP. On drawer contained a Avelox 400 milligrams one mouth once a day. The eral tablets. Patient #4 know what the Avelox was listed on the patient's PMP. On drawer contained an over Tums 750 milligrams. The took one by mouth "once in not listed on the PMP. There reder for Tums. Incy's policy, Medication and Procedures Manual for 000 MED-PASS, Inc. The nurse or therapist will medications(s) to the Discontinued ("D/C") ocumented and dated. The III be reviewed every home | G | 337 | | | |